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RESEARCH

Use of Cross-Border Healthcare Services by Elderly Turkish Migrants in Denmark: A Qualitative Study and Some Critical Reflections about Public Health 'Concerns'

Anne Leonora Blaakilde¹, Signe Smith Jervelund², Suzan Yazici³, Signe Gronwald Petersen⁴ and Allan Krasnik²

¹ Department of Media, Cognition and Communication, University of Copenhagen, Copenhagen, DK

² Department of Public Health, University of Copenhagen, Copenhagen, DK

³ Department of Gerontology, Akdeniz University, Antalya, TR

⁴ Sønderborg Municipality, Sønderborg, DK

Corresponding author: Anne Leonora Blaakilde (ablaa@ruc.dk)

Cross-border healthcare use among elderly Turkish migrants living in Denmark has been of concern in regards to their compliance with Danish healthcare provisions. A qualitative study of 30 elderly Turkish migrants was conducted, and the analysis led to the construction of two types of users: acute and intentional. The acute users respected the authority of the Danish healthcare system and only sought the use of healthcare services in acute situations whilst in Turkey. In contrast, the intentional users planned to consult and buy healthcare services whilst in Turkey. It was concluded that national health authorities should acknowledge and appreciate the benefits of transnational health practices represented by those groups of migrants who, in cooperation with their doctors, are competent users of cross-border healthcare services. The results of this study call attention to scholars of health and migration to be aware of our own 'concerns', which may represent spots of blindness hindering important and surprising insights.

Keywords: Cross-border; Migrants; Healthcare use; Transnational; Denmark-Turkey

Introduction

Global Ageing is a term describing the fact that the world's population aged 65 and over is increasing. The World Health Organization (WHO) mentions this as a major challenge to health and social systems and calls for attention to support good health in older people (WHO 2015). Parallel to this, migration has been identified by the WHO as a challenge to national health systems, because the healthcare needs of migrants should be integrated into national plans, strategies and policies. Governments are encouraged to recognise the need for a paradigm shift in how to handle health and migration and how health systems and related policies address migrants' health (WHO 2010) at a time when the world faces an estimated 250

million international migrants and 763 million internal migrants (WHO 2018). The call for attention towards the health of migrants is especially relevant in their later life, as the health of these elderly migrants may be particularly vulnerable due to high levels of morbidity, language barriers, low health literacy and cultural factors, which may influence their health-seeking behaviours (Kristiansen et al. 2016). In 2013, migrants above 65 represented 11% of the total migrant population (UN 2013), and the number of former labour migrants aged 65 or more is increasing (UNECE 2016). Following this, there is a growing academic interest for issues related to migration and old age (Ciobanu et al. 2017; Näre et al. 2017; Torres and Karl 2015; Warnes and Williams 2006). There is a need for more knowledge concerning the health situation, the provision of healthcare services, healthcare access and the health practices of the vulnerable population group of elderly migrants (Kristiansen et al. 2016; UNECE 2016). Use of cross-border health care services and medication may for instance be due to inequity in access to such services in the host land, which is observed among the Hispanic population in the US (De Jesus & Xiao 2013). On the other hand, in the UK, where Latin American migrants have access to national health care services, a series of cross-border health seeking strategies are performed due to other barriers, such as language (Gideon 2011).

Danish health scholars have called attention to differences in migrants' utilization of somatic healthcare services compared to non-migrants in Denmark (Norredam et al. 2009), showing concern for inequality in health and effects of medicine, compared to ethnic Danes, especially if the migrants obtain medicine from their home countries and do not follow the health care regimes in their host country (Hoffmann 2009; Nielsen, Hempler et al. 2012a; Nielsen, Yazici et al. 2012b).

The use of cross-border health services naturally invites a transnational frame, which is a recent and welcome perspective in migration studies (Horn & Schweppe 2017; Hromadzig & Palmberger 2018; Torres 2013; Vertovec 2009; Walsh & Näre 2016), because transnational, global and mobile aspects are embedded in many migrants' everyday lives.

The transnational lifestyle of elderly migrants has to be taken into account; studies must incorporate their circulating lives between countries and their integration of elements from one culture into the other (Bolzman et al. 2017; Swane & Tireli 2011b; Üçok 2006).

This qualitative study focuses on elderly Turkish migrants living in Denmark and their use of cross-border healthcare services. The aim of the study is to investigate the practice, motivations and intentions experienced by this group of migrants when they consume healthcare services and medication from their homeland, Turkey.

Do elderly Turkish migrants in Denmark use medicine and health care services from abroad, and if they do so, what are their motivations for doing this? Is it possible to detect if such a practice of cross-border consumption might be representing a risk to this population; a concern which has been raised by health professionals?

The article is divided in three parts: In the first part, key concepts and the background for the study is presented, including a presentation of Turkish migrants in Denmark and their situation, especially concerning health. In the second section, the qualitative study is presented with a methodology section and analyses of the 30 interviews with elderly Turkish migrants living in Denmark. The third section is a theoretically informed discussion about what we can learn from the findings of the qualitative study about use of cross-border health care services among elderly Turkish migrants living in Denmark.

Research Context and State of the Art

One of the consequences of mobility across borders is the increased opportunity for the cross-national use of healthcare services. This topic has a governmental interest for nation states and for the governance of the healthcare services (i.e., within the EU) (Suñol et al. 2009;

Wismar et al. 2011). In this study, the term cross-border healthcare services is defined as health services provided by general practitioners, dentists, hospitals and medical specialists, as well as the use of all medication, including medicine bought online or medicine acquired in a country other than the country of residence.

It is quite difficult to write in general terms about migrants, because the concept 'migrant' contains a multilayered definition of many kinds of people from various places in different situations and health conditions (Christen and Balthasar 2017; Nazroo 1998; Torres 2001; UN 2013). This is valid for instance in relation to host and home-countries, societal structure, culture, class, gender and age. Therefore, studies are recommended to focus on distinct, selected ethnic groups (Kristiansen et al. 2016; Salway et al. 2007).

Hence, when the concern is use of healthcare services among elderly migrants in Europe, the results may be varied and divergent, depending on the choice and criteria of the research methodology and material (Karlsen & Nazroo 2002; Norredam, Nielsen & Krasnik 2009).

Studies of ethnic minority citizens in the USA, New Zealand, the Netherlands and Denmark have found that many of these minority groups obtain healthcare in their country of origin, and this is especially true for the Turkish population, but the reason for this is not known (Nielsen, Hempler et al. 2012a; Şekercan et al. 2014; Nielsen, Yazici et al. 2012b). Because Turkish citizens comprise the second largest national non-Western migration group in Denmark (Statistics Denmark 2019), the cross-border healthcare behaviours of the group of Turkish elderly migrants were chosen as the focus of the present study.

A variety of studies regarding migrant patients in Denmark have indicated that the availability of high-quality care and healthcare services are one of the main motivations for staying in the host country (Kristiansen et al. 2015; Lokdam et al. 2016). Previous studies concerning elderly Turkish migrants living in Denmark have focused on their mental health (Mirdal 2006), dementia (Schmidt et al. 2016), mortality (Ankestyrelsen 2014), economic and work situation and life course and family life (Liversage 2017a; Liversage 2017b; Liversage & Jakobsen 2016; Liversage & Mirdal 2017; Mirdal 2006). This illustrates that they are, in many ways, in a disadvantaged position when compared to ethnic Danes.

Turkish migrants in Denmark

Turkish immigration to Denmark began in the 1960s, with migrants attracted to the market for unskilled labour in industry. Today, a significant part of this migrant group is growing old in Denmark. By 2020, 13.9% of the Danish population was comprised of migrants and 6.1% of the Danish population originated from non-Western countries. The Turkish population was the second largest, in 2019 comprising 8% (64,172 persons) (Udlændinge- og integrationsministeriet 2019) of the Danish population, and 6.5% (4,174) of these Turkish migrants were above 60 years old by January 1, 2020, a number that is naturally growing with increasing life expectancy (Statistics Denmark 2020).

In general, the income, labour market participation and health status of non-Western migrants in Denmark are considerably lower than among ethnic Danes and migrants of Western origin (Jervelund et al. 2017). Turkish elderly migrants in Denmark account for a higher rate of chronic ailments, such as arthritis, diabetes and locomotor and psychological symptoms, especially among women (Kessing & Krasnik 2013; Singhammer 2008) and a higher proportion of self-reported illness (Nielsen, Hempler et al. 2012a; Singhammer 2008). Additionally, adult Turkish migrants are at a higher risk of health problems and morbidity than ethnic Danes; furthermore, the health differences increase more by age for Turkish migrants (Nielsen, Hempler et al. 2012a; Singhammer 2008).

Compared to their Danish counterparts, Turkish migrants living in Denmark use somatic health services (general practitioners [GPs], specialist doctors, hospitals and dentists) to a higher

degree whilst travelling abroad in a foreign country. Among migrant Turkish women there is a considerable higher use of medicine received from abroad (Nielsen, Yazici et al. 2012b).

In a longitudinal qualitative study in Denmark, the somatic and mental health of Turkish migrant women were found to be in a poor condition with high levels of distress both in 1984 and then again in 2006, even though the material situation of the women had improved over time (Mirdal 2006). Danish studies that investigated the social life of different groups of elderly migrants, one of those groups being Turkish, reported that distress among elderly migrants can be caused by various social and cultural phenomena, such as fear of loneliness or isolation, meaninglessness, poor life satisfaction and longing for their home country (Swane & Tireli 2011a; Tireli et al. 2007).

Most healthcare services are free of charge for Danish residents as they are financed by state and municipal taxation, while approximately 14% of the health expenditure is direct out-of-pocket payments (mostly drugs, dental services and glasses) (Olejaz et al. 2012). Turkish migrants have a higher use of healthcare services and medication compared to ethnic Danes (Hempler 2010; Nielsen, Yazici et al. 2012b). Variations in consumption patterns may reflect variations in need, socio-economic status and healthcare-seeking behaviour. Language and culture are also likely to play a role in expectations and practices of health care (Nazroo 1998; Üçok 2006). Due to the Turkish migrants' transnational practice of going back and forth between their homeland and host-land (Swane & Tireli 2011a; Swane & Tireli 2011b; Üçok 2006), which is known from other host countries as well (Baykara-Krumme 2013), it can be suspected that they particularly appreciate the provision of health services from their home country, Turkey. However, public health professionals have expressed concern about the use of cross-border healthcare services among migrants (Nielsen, Hempler et al. 2012a).

Concerns about cross-border use of healthcare services and medicine

Concerns about health care services and medication bought abroad by migrants are stated by medical health professionals, first and foremost because this practice might have a negative impact on the levels of compliance with the requirements of optimal health treatment, and also because such transnational practices may disrupt the continuity of care in the host country (Hoffman 2009). Secondly, another concern is that such cross-border usage may cause an increase in the already observed degrees of inequality in the use of healthcare services and also in the health situation of migrants compared to ethnic Danes (Hempler 2010; Hoffman 2009; Nielsen 2010). Thirdly, *The Danish Medicines Agency* presents a concern regarding the intake of medicine from foreign countries, which is suspected of being highly problematic, because the quality can be questioned due to a lack of proper control, which can create a risk for the patient (Nielsen, Yazici et al. 2012b). It has even been stated that such cross-border use of medicine could cause an 'alarming' situation (Hoffmann 2009). Furthermore, concerns regarding patient safety and continuity of care have been raised as an even more compromising risk in the case of elderly people, who are more likely to be in a poorer health state and therefore using more medication and healthcare services than younger people.

The medical doctor and anthropologist Arthur Kleinman claimed that conceptions of health and illness are always culturally shaped because human experience of illness, as well as diagnoses and treatments by practitioners, are based on historical and socio-political phenomena, for which Kleinman coined the phrase health explanatory models (Kleinman 1978). Kleinman suggested the term healthcare system for explanatory models that are systematised into a practiced body of knowledge of health treatment. The most dominant healthcare system in the world, according to Kleinman, is the Western medical regime. Acknowledging that cultural factors may influence health-seeking behaviours (Kristiansen et al. 2016), this study

is inspired by Kleinman's recommendation to show concern and attention towards derivations from the Western healthcare model.

Based on this knowledge from the literature, these three areas of concern are the points of departure for this study: 1) Turkish migrants may have a different health explanation model compared to ethnic Danes, 2) cross-border healthcare and medication use might adversely affect compliance with the health treatment in the host country and 3) patients' cross-border mobility can be a risk for patient safety and continuity of care. These concerns were investigated by asking some of the elderly Turkish migrants living in Denmark.

After the presentation of the qualitative study (part 2), a theoretically informed discussion will follow (part 3).

The Qualitative Study

In total, 20 interviews with elderly Turkish migrants living in Denmark were conducted between 2011–2012. Ten of the interviews were conducted with couples, making a total of 30 people interviewed. Overall, the study comprises information from 12 men and 18 women aged between 54 to 80. We included a broad interpretation of 'being elderly', because Turkish migrants in Denmark tend to age and catch diseases earlier in life than native-born Danes (Liversage 2017; Liversage & Jakobsen 2016). The interviewees were recruited from five different areas in Denmark, representing two neighbourhoods and one suburb of Copenhagen and two areas in the rural outskirts of Denmark. This selection represents geographical areas that contain both a high and a low percentage of elderly Turkish inhabitants. Respondents were found with the help of professionals, semi-professionals and volunteers in health and social services operating in the five areas. The interviews were carried out in accordance with the Danish Law on Personal Data, which means that all participants were guaranteed confidentiality and all names were anonymised.

Except for two, all interviews were conducted in the homes of the respondents, and sometimes family members or neighbours participated, which should be taken into consideration concerning the information we obtained. In such cases, we did not speak about highly sensitive subjects, such as mental illness or depression, which was mentioned in some of the single interviews. The atmosphere in the homes in general was very friendly. Being in the homes is considered an important part of the fieldwork of participant observation as it allows for a deeper understanding of the daily lives and customary practices related to the health of the participants. The interviews were mainly done in Turkish, because most of the respondents spoke very little Danish or they felt more comfortable speaking in Turkish. Questions were asked in Turkish and answers summarised in English during the interview in order to engage the non-Turkish speaking researcher in the interviews. Any additional questions were asked in English and translated into Turkish. The semi-structured interviews had a duration between 1 and 2.5 hours, and they were subsequently transcribed into both English and Turkish by the Danish and the Turkish interviewers. The interview questions focused on the participants' life and health practices in Turkey prior to migration, the decision to migrate, the actual migration events, the experience of coming to Denmark, the participants' life and health practices today, including healthcare services obtained in Turkey and reflections about changes in the participants' lives as a result of migration. Furthermore, questions were asked about the participants' expectations or worries about the future and their reflections about remigration. The transcriptions were finally thematically content-analysed (Kvale 1996). This means that a list of themes was constructed that categorised the interviewees by their individual content, for instance education, family life, illnesses, their own attitudes towards illnesses and the cause of illness, and so forth. This created a basis for the characterisation of

the 30 interviewees. Specific utterances about the participants' experiences with healthcare services and medication in Turkey and Denmark were then analysed in more detail.

Several considerations can be posed regarding the methodology of this study. The presence of a Danish as well as a Turkish person in the interview situation, may have had an impact on the answers given. The language spoken was Turkish-Danish-English, and extracts of the conversation had to be translated simultaneously for everyone to follow. The presence of the Turkish medical doctor was probably key to establishing a sense of confidence, which allowed the respondents to talk freely in their mother tongue. As a representative of a Danish research institution, the Danish researcher may be perceived as a part of Danish officialdom and associated with the 'authorities', which for some of the migrants did not represent positive experiences. Research based on (quantitative as well as qualitative) questions may always contain a hesitation for the truth value of the responses, and it is not known if the interviewed migrants had by chance heard about the health authority's concerns regarding cross-border healthcare use, which could have inclined them to downsize the telling of their own practice in this regard.

The respondents were clearly hesitant to inform about the amount of time spent annually in Turkey because Danish law prohibits longer stays abroad for residents of Denmark. It was obvious to the interviewers that this was a critical topic because answers were negotiated between family members during the interview. None such impressions occurred to the interviewers while the topic of cross-border health practices was discussed.

Different practices regarding use of cross-border health care services

The results of the qualitative study are introduced through the characterisation of the interviewees, followed by answers to the questions related to the use of cross-border healthcare services and medicine. In the analysis we identified two different types of users of cross-border health care services, namely intentional and acute users, which will be explained.

Characterisations

Of the 30 persons interviewed, only 2 were attached to the labour market. The majority were either unemployed, on sick leave, in early retirement or retired. Five of them were illiterate (all women), 15 of the migrants had 5 or fewer years of education, another 3 Turkish interviewees had 5 to 8 years of education and 7 of them had 8 or more years of education. From the interviews and conversations, it was estimated that 23 of the 30 respondents had poor Danish language skills, 7 had good competencies in Danish, and a few of them spoke English as well. The 30 participants had stayed in Denmark for between 14 to 45 years, and for 26 of them, the migration incentive was to find work or to follow a working husband. Three of them had migrated for political reasons, and one in order to teach. Most of them originated from rural areas and rather poor living conditions in Turkey and found religion (Islam) to be important. While in Denmark, most of them had been occupied with hard, manual work, such as industrial work, gardening, cleaning and work in nursing homes, and five of them had worked (and some still did) as teachers. The majority were living on public means (pensions, social security), and this indicated a low economic status. All of them were living in rented apartments. However, they all indicated that they spend time in both Turkey and Denmark. Most of them had houses in Turkey, though they were residents in Denmark and spent most of their time in their host country. These characteristics are in line with other studies of elderly Turkish migrants in Denmark (Liversage & Jakobsen 2016). The furniture and other interior decoration, the food and the on-going Turkish TV programmes in their homes were clear indicators of strong ties to Turkey. During the visits, the participants' friends and family were always coming by. The networks of these Turkish people seem very close-knit. Few of them declared to having Danish friends.

Apart from one interviewee, all suffered from at least one, and often several, chronic diseases, such as diabetes, cancer, asthma and rheumatic disease, thereby many of them represent multi-morbidity and poly-pharmacy. Many of them said that they felt old and ill. Among the 30 respondents, 4 claimed to use no medicine at all and 4 did not answer this question. All other participants claimed that they consumed at least one drug on a daily basis.

Findings

In order to stay healthy, most of the interviewees claimed to be aware of certain health practices, which they stated they had learned primarily from the Danish medical authorities or from the Turkish TV programme *The Doctors*, which is broadcast worldwide and very popular to watch among the Turkish people we met. It is a doctor's programme with health advice and recommendations in Turkish, adhering to the Western health care model:

I learned about diabetic food from the TV; I never miss *The Doctors* program on the TV.
(Turkish woman, aged 57)

Because *The Doctors* is a popular TV-programme among Turkish migrants in Denmark, it also reveals that there seems to be a congruence between the information from Danish medical authorities and Turkish medical practices, which is distributed through popular Turkish media. This finding seems to answer the first concern about the elderly Turkish migrants having a different health explanation model compared to ethnic Danes, which is not the case. However, it was found that responses and attitudes to the Danish health care system varied among the people interviewed. The analysis shows that a typological differentiation can be established between intentional and acute use of healthcare services whilst abroad. An intentional use was indicated by planned actions of medical consultation and purchases of medicine whilst abroad, whereas an acute use of healthcare services was unplanned and emerges only when needed whilst abroad. This will be explained in the following.

Acute users of cross-border health care services

The majority of the interviewees belonged to the latter type, stating that they had trust in their Danish GP and did not wish or dare to mix the advice from Danish health authorities by visiting Turkish doctors or by buying medicine in Turkey. They indicated that they normally do not use cross-border health care services in their homeland except for dentists, which are considerably cheaper than in Denmark. However, while sojourning in their homeland, and in cases of emergency or sudden illness that required medication, many of them had experienced a visit to a doctor or bought medicine in Turkey. As an example, one couple said:

I: Do you buy medicine from Turkey?

F: We buy it there if we get sick there.

I: What about your drugs for diabetes?

F: We bring that from Denmark.

I: Did you consider buying drugs from Turkey because they are cheaper there?

F: No, we didn't.

M: I considered buying drugs in Turkey. I need B12 vitamins as injections. They are very expensive in Denmark. I have heard that they are much cheaper there. I am not sure whether the ingredients are the same, and we are afraid to mix it; that is why we bring all our drugs from here when we go to Turkey.

(I: Interviewer; F: wife, 55; M: husband, 62)

Characteristic of this interview concerning the acute consumption of medicine from Turkey is a very authoritative approach to the Danish medical system expressed by the interviewees; even though the price may be lower, the couple does not dare to mix between the two medical systems.

Intentional users of cross-border healthcare

Intentional users consisted of 6 of the 30 persons interviewed who indicated that they intentionally used the healthcare services in Turkey and planned to buy medicine there or they even had the required medicine brought to them in Denmark by friends. Among these six, three persons had more than eight years of education; the other three were illiterate housewives who did not speak the Danish language.

The motivations mentioned need to be addressed. These motivations diverge in some ways, which is important knowledge for further investigations regarding the practice and backgrounds for such transnational practice. The reasons indicated by these six persons relate to price, communication problems and the ease of access to the healthcare services in their homeland.

One important reason for using these healthcare services is the price differences between the two countries:

[In Denmark] I pay 890 DKK (€ 119) for one box of 56 tablets. How much do I earn? Our rent is so high. They [Danish social security] support other medications, but not this one. I have ordered it from Turkey now. Five boxes. It is the same medicine. (...) Now it is 30 TL (€ 9.68); 60 for two boxes there, about 900 DKK here (120 €). (Turkish woman, age 64)

In the first instance, the Danish doctor had told this woman not to get drugs from Turkey, but as he checked the Turkish medication in the medical files, he realised that the types of medicine were similar. She was one of the illiterate persons in the study. Among the three more educated migrants in this group, it was revealed that they controlled the content of the medicine themselves. They found cheaper but similar products in Turkey, so they correlated with the drugs prescribed by their Danish GP. Another (educated) woman was suffering from Mediterranean Fever, a disease that is rare in Denmark, and her Danish GP recommended that she buy the drugs in Turkey because the price is three or four times higher in Denmark. Hence, in several cases, the Danish medical doctor was involved in the decision to purchase cheaper but similar medicine from Turkey. These findings are in line with other studies among Hispanic US citizens who transgress the border of Mexico due to lower prices and their economic situation (De Jesus & Xiao 2013), but they also show that there is a cooperation between patient and GP about this.

Communication problems in Denmark represent one of the reasons for the use of medical assistance as was explained by a few of the interviewees who used cross-border health services. The illiterate interviewees who do not comprehend Danish expressed their experiences of serious communication problems and indicated that they would like to have a Turkish doctor in Denmark because of the communication problems. Some of them had had negative experiences with interpreters. In some cases, the use of Turkish healthcare services was fuelled by the patient's desire for a second opinion in a language they could understand. Some of them reported very positive results from their cross-border experience. One woman told about a visit to a Turkish hospital where a MR scan was made and resulted in a specific diagnosis and the prescription of medication. This, in turn, had an effect on her treatment in the Danish medical system:

F: [I brought] tablets and injections from Turkey. I went to the doctor in Turkey (...). Here [in Denmark] they just give you a mild painkiller. There, I had an MR scan and a bone scan. Osteoporosis; it is getting worse every year. I have to use drugs for the rest of my life. He [the Turkish doctor] wrote me an English letter about my medications and told me to bring it to my doctor [in Denmark]. My Danish doctor saw the scan results and sent me for another screening. The result was the same, so I get my medicine here now. (Turkish woman, age 67)

However, the general experience of the elderly migrants who went to Turkey as well as Danish doctors is ambiguous. The interviewees present stories of both trust and distrust in equal measures. Some interviewees mentioned that the healthcare service is more accessible in Turkey, especially because of less effective advice and treatment in the Danish public healthcare system and long waiting times for health tests and treatments in Denmark. According to this finding, an underlying critique of the health care system in Denmark is presented by a few of the interviewees who had negative experiences of support from Danish health care services.

According to the interviewees' statements about Danish GPs and the use of medicine, the migrants seem to respect the authority of the Western healthcare model represented by the medical service in Denmark, a model which is also dominant in the Turkish healthcare system. The popular Turkish TV-show *The Doctors* testifies to this: there is no obvious or significant discrepancy regarding the different health models in Denmark and Turkey (Kleinman 1978). In line with this, some of the recommendations from their Danish GPs were an incentive to cross-border consumption for both the educated and the illiterate group.

Analysis

Quantitative studies have shown a larger use of cross-border healthcare services by Turkish migrants living in Denmark compared with ethnic Danes (Jervelund 2015; Nielsen, Yazici et al. 2012b). In this qualitative study, the depth of knowledge from the interviews of elderly Turkish migrants in Denmark show that it may be necessary to differentiate between the motivations for such use of cross-border healthcare services. When distinguishing between acute and intentional consumers of cross-border healthcare services, we suggest that a good part of the accounted use in previous studies may be due to accidental and improvised purchase and consumption of medical services whilst the Turkish migrants are visiting in their homeland. It also becomes clear that this kind of consumption was not desired by the majority of the interviewees; they actually prefer to follow the authority of their Danish doctors and medical prescriptions from Denmark. This practice should thereby be of less concern for the Danish medical authorities.

However, it is important to obtain more information about the smaller group of intentional consumers who plan to use healthcare services and buy medicine whilst in Turkey. The motivations for such intentional cross-border healthcare use differ among the interviewees. Communication and competence seem to be important for the Turkish migrants who are lacking Danish language skills and/or literacy skills and relying upon help in communicating with their GP. If the communication with their GP is satisfactory, they seem to be very respectful towards the authority of the doctor. If they lack language competencies, and therefore experience communication problems with their Danish GP, they may turn to a Turkish doctor. However, only a few of the interviewees talked about negative experiences regarding their encounters with the Danish healthcare system. This general satisfaction with the Danish healthcare services among the majority of the Turkish interviewees seems to be a

salient reason why there is no more intentional use of cross-border health care services and medicine observed in this study, even if the language may cause problems. Likewise, contradictory practices regarding the use of Danish and Turkish healthcare services do not seem to be predominant.

It is important to note that negotiations of healthcare solutions do occur and involve both the Danish and the Turkish healthcare systems. This is exemplified when interviewees watch the Turkish program *The Doctors* whilst they also listen to advice from their Danish GP. Furthermore, some of the interviewees seem to acknowledge and appreciate advice from both parts, and there is a discussion about the advice given by one national health authority with another. A specifically competent negotiation and evaluation between national health systems seems prevalent in the cases where the medication users do intentionally search for better or more specified treatments or medication. They investigate, consider and decide what seems to be the most efficient or cheapest solution to their own health problems. This can also occur in collaboration with a medical doctor from the two countries, respectively, for example, in the case of a special disease such as Familial Mediterranean Fever or when an MR scan from Turkey allows for better medical treatment in Denmark. These competent negotiations about proper healthcare are going on in a respectful and troubleshooting dialogue where the Turkish patient, the Danish GP and/or professionals in the Turkish healthcare system are transgressing the established national borders in order to find the most effective solution(s). These examples seem to represent a high degree of communication and competence and also exemplify the positive effect of a transnational healthcare practice (Bilecen & Tezcan-Güntekin 2014).

In general, the study could not contribute to the concern from Danish medical authorities that the use of cross-border health care services may generate a lack of compliance with the Danish healthcare system. Contrarily, it was found that in the few cases when Turkish migrants intentionally negotiate and evaluate their healthcare practices in both countries with health authorities, this seems to represent a qualified rationale, which may be beneficial for their health situation.

Theoretically informed discussion

Turning to a critical vein within ethnic minority studies (Smaje 1996; Torres 2001), a reflexive approach needs to be taken to discuss what can be learned from studies like this by reconsidering the points of departure and the results.

As a point of departure in this study, three concerns regarding use of cross-border healthcare services and medication were carried forward:

- 1) Turkish migrants may have a different health explanation model compared to ethnic Danes.
- 2) Cross-border health and medication use might adversely affect compliance with the health treatment in the host country.
- 3) Patients' cross-border mobility may be a risk for patient safety and continuity of care.

The study did not confirm any of these presumptions. In this section, we will take the discussion to a further step with inspirations from a variety of theoretical thinkers, because we intend to ask why did these three concerns seem relevant and intriguing? What can we learn from our own study and interest in this subject?

Peter Berger and John Luckmann (1966) stated, from the point of view of constructivism, that meaning and values are perceived as common-sense perspectives, which make them

almost imperceptible to the people inhabiting them. The meanings of the social world tend to be comprehended as objectifications, a term for social phenomena that seem natural as parts of objective reality, even though they are socially constructed (Berger & Luckmann 1966). In order to grasp the complexity of social life and institutions, typifications are necessary for people's cognition of the world, according to Berger and Luckmann (1966). Such typifications not only create meaning by way of including certain phenomena in categories and entailing them with certain characteristics, but also they simultaneously act as exclusions against other phenomena by establishing differentiations, for instance, by age, by national background or by cultural background. A typification does not represent a fixed entity but is always presented by means of a certain perspective.

The three concerns in this study could be seen as typifications about Turkish migrants as conveyed by public health and medical researchers (including the authors of this study) who represent the Danish health authorities. Turkish migrants were presupposedly perceived as a typification of a certain health explanatory model that is different from the Western medical model. This presumption did not align with the circumstances found in the study, and as such, the results exposed typifications from the researchers' point of view, not only of Turkish migrants, but maybe also of a specific Turkish medical explanatory system. Such a typification can be read as a marking of the 'normativity of privilege' of one's own position as the representative of normality (Scambler 2012), connoting the 'otherness' of the migrants studied (Zubair & Norris 2015). These concerns brought forward by the Danish healthcare system represent a position from where a problematisation is claimed. Problematisation is a theoretical concept introduced by Michel Foucault that points to the effects produced by a system of power, which, by means of selecting, naming and claiming certain phenomena as problems, imply positions of difference, otherness and exclusion (Rabinow 1984). Hence, problematisation denotes a construction of hierarchical positionings by means of coining a specific phenomenon as a problem and as subordinate to another.

Migration scholars have pointed to the fact that presumptions about migrants are often influenced by typifications regarding traditions, family life, religion or specific diseases (Magnússon & Kiwi 2011; Taylor 2013; Torres 2012), which even tend to connote 'problematic others' as a preamble to migration groups (Torres 2006) if they seem to represent divergences from common objectifications. In a way, the three concerns in this study testify to such a typification, because they may rely on the presumptions of the interviewees perceived as uneducated and ignorant users of healthcare and medication (Smaje 1996). However, the study showed varied results that significantly nuanced this perspective. The results presented healthcare service users as both authoritative and competent. Especially regarding the most competent of the consumers of cross-border healthcare services, it can be said that they perform a transnational competence, which is not in congruence with the typification of the 'problematic other' (Torres 2006).

This perspective seems to present an objectification that included presuppositions about what is considered to be the correct or incorrect health treatment in a Danish context and also of national borders as a delineation of what is considered to be trustworthy. In this way, the problematisation of cross-border use of healthcare services could be seen as an incidence of 'methodological nationalism', pointing to a typification of a nation/state/society being perceived as a natural social and political form for the modern world (Wimmer & Glick Schiller 2002: 301).

The practice of mobility is a constituting factor for societies and life-worlds (Adey 2010), and in the study of migrant lives, mobility is a key perspective of the migration itself. In studies of elderly Turkish migrants, it is pertinent to take a transnational perspective, which means

incorporating the practice of circulation between two or more countries and the implications connected to this (Bilecen & Tezcan-Güntekin 2014; Bolzman et al. 2017; Levitt & Jaworsky 2007). This enables new understandings of the use of cross-border healthcare services and medicine by elderly Turkish migrants living in Denmark.

This critical, reflexive perspective reveals that the research project was confined by demarcated national borders, even though the topic is from a cross-border perspective. This is particularly interesting because some interviewees in the study indicate that they find the Turkish healthcare service to be of a better quality than the Danish one. Objectifications regarding the nation state as a natural frame for social and political considerations and for its health practices should call upon these considerations. Critical reflections of such problematisations by the researchers are propounded by the disciplinary field of ethnicity and health and need to be further considered. A reflection upon the presumptions and objectifications embedded in individuals needs to be included.

By carrying out qualitative interviews and asking elderly Turkish migrants about their use of cross-border healthcare services, it was discovered that even though the interviewed migrants were ill and frail in different ways, some of the respondents were more competent than expected, and it was found that a constructive negotiation between the partners, with patients and doctors in both countries being involved, is saturating the borders. Furthermore, it was uncovered that a reflexive view on the researchers' own presumptions may illuminate a delimiting methodological nationalism.

Transposed to studies of ethnicity and health, and to studies like the present one, this points to an important call for attention to widen society's horizons and be reflexive about scholarly typifications, which may, in certain instances, even risk representing stigmatization (Pussetti & Barros 2012). More knowledge is needed about the lives of the elderly migrants in order to find explanations for their general higher level of ill health. Concurrently, it is important not to typify a migrant as the problematic other based on typifications inherent in researchers and health professionals, which may prevent a constructive change from concerns to appraisal of transnational competencies.

Conclusion

The Turkish migrants interviewed represented a variety of illnesses and therefore supports the general indication of multi-morbidity, indicating that they need health care services, but there are no indications in this qualitative study that their use of cross-border healthcare services, nor any of their specific health explanatory models, could attest to their unhealthy situation. The interviewees were divided into two groups of users of cross-border healthcare services. Out of respect for the authority of their Danish doctors and medical prescriptions, the largest group did not intend to use medical services or medicine while sojourning in Turkey, but it might have happened in certain acute situations. This group is entitled the acute users of cross-border healthcare services. The other, smaller group is entitled the intentional users, and these users planned medical consultations and the purchase of medicine during their visit to Turkey.

The intentional users can furthermore be subdivided into two groups: one authoritative but illiterate group, who chose healthcare services in Turkey because of ease of communication, and another group of rather concerned, informed and competent users of healthcare services and medicine, some of them even critical of the Danish healthcare system. In some of these cases, constructive cooperation with their general practitioner in Denmark was reported, which gives the impression of a transnational practice of healthcare services and medication and is of no threat to the consumers but which should be viewed in a more productive light as a transnational competence.

What is furthermore learned from this study is that from a reflexive point of view, scholars and health professionals in general, when talking about public health concerns, should be aware of our own presumptions and typifications about migrants and their health practices, because the intriguing questions of this study initially were based on presumptions about the use of cross-border health care services among elderly Turkish migrants in Denmark perceived as a negative and, presumably, risky practice. What was observed was more nuanced, more conscious and more skilled cross-border behaviours than expected, embedded in a transnational mobility, which is probably a more well-tested experience among migrants than among non-migrants.

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Competing Interests

The authors have no competing interests to declare.

References

- Adey, P.** 2010. *Mobility*. London and New York: Routledge. DOI: <https://doi.org/10.4324/9780203875483>
- Ankestyrrelsen.** 2014. *Indvandrere lever længst*. [The Council of Appeal. Migrants represent the longest life expectancy]. Denmark.
- Baykara-Krumme, H.** 2013. Returning, staying, or both? Mobility patterns among elderly Turkish migrants after retirement. *Transnational Social Review*, 3(1): 11–29. DOI: <https://doi.org/10.1080/21931674.2013.10820745>
- Berger, PL and Luckmann, T.** 1966. *The Social Construction of Reality. A Treatise in the Sociology of Knowledge*. Anchor Books.
- Bilecen, B and Tezcan-Güntekin, H.** 2014. Transnational healthcare practices of retired circular migrants. In: Faist, T (ed.), *COMCAD Arbeitspapiere [Working Papers]*, 27. Germany: Bielefeld University.
- Bolzmann, C, Kaeser, L and Christe, E.** 2017. Transnational mobilities as a way of life among older migrants from Southern Europe. *Population, Space and Place*, 25(5): e2016. DOI: <https://doi.org/10.1002/psp.2016>
- Christen, D and Balthasar, A.** 2017. Approaches to improve the interaction between general practitioners and migrants – a systematic review of international literature. *International Journal of Migration, Health and Social Care*, 13(32): 321–333. DOI: <https://doi.org/10.1108/IJMHSC-10-2015-0037>
- Ciobanu, O, Fokkema, T and Nedelcu, M.** 2017. Ageing as a migrant: vulnerabilities, agency and policy implications. *Journal of Ethnic and Migration Studies*, 43(2): 164–181. DOI: <https://doi.org/10.1080/1369183X.2016.1238903>
- De Jesus, M and Xiao, C.** 2013. Cross-border health care utilization among the Hispanic population in the United States: Implications for closing the health care access gap. *Ethnicity & Health*, 18(3): 297–314. DOI: <https://doi.org/10.1080/13557858.2012.730610>
- Gideon, J.** 2011. Exploring migrants' health seeking strategies: The case of Latin American migrants in London. *International Journal of Migration, Health and Social Care*, 7(4): 197–208. DOI: <https://doi.org/10.1108/17479891111206328>

- Hempler, NF.** 2010. *Etniske minoriteter i det danske sundhedsvæsen – en antologi* [Ethnic minorities in the Danish Health Care System]. Danmark: Sundhedsstyrelsen.
- Hoffmann, T.** 2009. Indvandrere importerer lægemidler [Migrants are importing medication], 28 September 2009. Available at <https://videnskab.dk/kultur-samfund/indvandrere-importerer-laegemidler>.
- Horn, V** and **Schweppe, C.** 2017. Transnational aging: Toward a transnational perspective in old age research. *European Journal of Ageing*, 14: 335–339. DOI: <https://doi.org/10.1007/s10433-017-0446-z>
- Jervelund, SS** and **Handlos, LN.** 2015. Migrants use of healthcare in their country of origin. In: Lunt, N et al. (eds.), *Elgar Handbook on Medical Tourism and Patient Mobility*. London: Edward Elgar.
- Jervelund, SS, Malik, S, Ahlmark, N,** et al. 2017. Morbidity, self-perceived health and mortality among non-Western Immigrants and their descendants in Denmark in a life phase perspective. *Journal of Immigrant and Minority Health*, 19(2): 448–476. DOI: <https://doi.org/10.1007/s10903-016-0347-9>
- Karl, U** and **Torres, S.** (eds.) 2015. *Ageing in contexts of migration*. London: Routledge. DOI: <https://doi.org/10.4324/9781315817606>
- Karlsen, S** and **Nazroo, JY.** 2002. Agency and structure: The impact of ethnic identity and racism on the health of ethnic minority people. *Sociology of Health and Illness*, 24(1): 1–20. DOI: <https://doi.org/10.1111/1467-9566.00001>
- Kessing, LL** and **Krasnik, A.** 2013. Ældre migranternes sundhed – en ny udfordring for sundhedsvæsenet. In: Kessing, LL, et al. (eds.), *Ældre med anden etnisk baggrund – viden og inspiration til indsats* [The health of elder migrants – a new challenge for the health care system]. Danmark: Ældreforum. pp. 28–30.
- Kleinman, A.** 1978. Concepts and a model for the comparison of medical systems as cultural systems. *Social Sciences and Medicine. Part B: Medical Anthropology*, 12: 85–93. DOI: [https://doi.org/10.1016/0160-7987\(78\)90014-5](https://doi.org/10.1016/0160-7987(78)90014-5)
- Kristiansen, M, Kessing, LL, Norredam, M** and **Krasnik, A.** 2015. Migrants' perceptions of aging in Denmark and attitudes towards remigration: Findings from a qualitative study. *BMC Health Services Research*, 15: 225. DOI: <https://doi.org/10.1186/s12913-015-0901-5>
- Kristiansen, M, Razum, O, Tezcan-Güntekinc, H** and **Krasnik, A.** 2016. Aging and health among migrants in a European perspective. *Public Health Reviews* (Print), 37(20). DOI: <https://doi.org/10.1186/s40985-016-0036-1>
- Kvale, S.** 1996. *InterViews: An introduction to qualitative research interviewing*. London: Sage.
- Levitt, P** and **Jaworsky, BN.** 2007. Transnational migration studies: Past developments and future trends. *Annual Review of Sociology*, 33: 129–56. DOI: <https://doi.org/10.1146/annurev.soc.33.040406.131816>
- Liversage, A.** 2017a. Ældre indvandrere med behov for (hjemme)hjælp' [Elderly migrants in need of home help]. *Tidsskriftet Gerontologi*, 1: 10–15.
- Liversage, A.** 2017b. Twice as many helpers: Unpacking the connection between marriage migration and older labour immigrants' access to family support. *Migration Letters*, 14(1): 50–62. DOI: <https://doi.org/10.33182/ml.v14i1.315>
- Liversage, A** and **Mirdal, G.** 2017. Growing old in exile – a longitudinal study of migrant women from Turkey. *Journal of Ethnic and Migration Studies*, 43(2): 287–302. DOI: <https://doi.org/10.1080/1369183X.2016.1238910>
- Liversage, A** and **Jakobsen, V.** 2016. *En generation bliver gammel – ældre tyrkiske indvandreres liv i Danmark i dag* [A generation is growing old – the life of older Turkish migrants in Denmark today]. Danmark: Hans Reitzels Forlag.

- Lokdam, N, Kristiansen, M, Handlos, LN and Nørredam, ML.** 2016. Use of healthcare services in the region of origin among patients with an immigrant background in Denmark: A qualitative study of the motives. *BMC Health Services Research*, 16(99): 1–10. DOI: <https://doi.org/10.1186/s12913-016-1346-1>
- Magnússon, F and Kiwi, M.** 2011. Integration mot ohälsa. Äldre iranska kvinnor i Malmö [Integration towards ill health. Older Iranian women in Malmö]. *Socialmedicinsk tidsskrift*, 88(3): 225–32.
- Mirdal, GM.** 2006. Stress and distress in migration: Twenty years after. *International Migration Review*, 40(2): 375–89. DOI: <https://doi.org/10.1111/j.1747-7379.2006.00021.x>
- Näre, L, Walsh, K and Baldassar, L.** 2017. Ageing in transnational contexts: Transforming everyday practices and identities in later life. *Identities*, 24(5): 515–523. DOI: <https://doi.org/10.1080/1070289X.2017.1346986>
- Nazroo, JY.** 1998. Genetic, cultural or socio-economic vulnerability? Explaining ethnic inequalities in health. *Sociology of Health and Illness*, 20(5): 710–30. DOI: <https://doi.org/10.1111/1467-9566.00126>
- Nielsen, SS.** 2010. *Equity in Access to Healthcare Services for Migrants – A Comparative Study*. PhD-Thesis. Denmark: Department of Public Health, University of Copenhagen.
- Nielsen, SS, Hempler, NF, Waldorff, FB, Kreiner, S and Krasnik, A.** 2012a. Is there Equity in Use of Healthcare Services among immigrants, their descendents, and ethnic Danes? *Scandinavian Journal of Public Health*, 40(3): 260–70. DOI: <https://doi.org/10.1177/1403494812443602>
- Nielsen, SS, Yazici, S, Petersen, SG, Blaakilde, AL and Krasnik, A.** 2012b. Use of cross-border healthcare services among ethnic Danes, Turkish immigrants and Turkish descendants in Denmark: a combined survey and registry study. *BMC Health Services Research*, 12(1): 390–95. DOI: <https://doi.org/10.1186/1472-6963-12-390>
- Norredam, M, Nielsen, SS and Krasnik, A.** 2009. Migrants' utilization of somatic healthcare services in Europe—a systematic review. *European Journal of Public Health*, 20(5): 555–63. DOI: <https://doi.org/10.1093/eurpub/ckp195>
- Olejaz, M, Juul Nielsen, A, Rudkjøbing, A, Okkels, HB, Krasnik, A and Hernandez-Quevedo, C.** 2012. Denmark: Health system review. *Health Systems in Transition*, 14(2): 1–192.
- Pussetti, C and Barros, V.** 2012. The care of the immigrant self: Technologies of citizenship and the healthcare sector. *International Journal of Migration, Health and Social Care*, 8(1): 42–50. DOI: <https://doi.org/10.1108/17479891211231400>
- Rabinow, P.** 1984. Polemics, politics, and problematizations. An interview with Michel Foucault. In: *The Foucault Reader*. New York: Pantheon. pp. 380–90.
- Salway, S, Platt, L, Harris, K and Chowbey, P.** 2007. Long-term health conditions and disability living allowance: Exploring ethnic differences and similarities in access. *Sociology of Health and Illness*, 29(6): 907–30. DOI: <https://doi.org/10.1111/j.1467-9566.2007.01044.x>
- Scambler, G.** 2012. Review article. Health inequalities. *Sociology of Health and Illness*, 34(1): 130–46. DOI: <https://doi.org/10.1111/j.1467-9566.2011.01387.x>
- Schmidt, J, Kristensen, M and Rosenbaum, B.** 2016. Demenslidelser hos ældre tyrkiske indvandrere [Dementia in elderly Turkish immigrants]. *Ugeskrift for Læger*, 168: 4109–13.
- Singhammer, J.** 2008. *Etniske minoriteters sundhed*. Denmark: Region Midtjylland, Center for Folkesundhed.
- Smaje, C.** 1996. The ethnic patterning of health: New directions for theory and research. *Sociology of Health and Illness*, 18(2): 139–71. DOI: <https://doi.org/10.1111/1467-9566.ep10934605>

- Statistics Denmark.** 2020. FOLK1c. [Last accessed 30 March 2020].
- Suñol, R, Garell, P and Jacquerye, A.** 2009. Cross-border care and healthcare quality improvement in Europe: The MARQuIS research project. *BMJ Quality & Safety*, 18: i3–i7. DOI: <https://doi.org/10.1136/qshc.2008.029678>
- Swane, CE and Tireli, Ü.** 2011a. Tyrkiske ældres bestræbelser på at føle sig hjemme [Elderly Turkish peoples' efforts to feel at home]. *Social Kritik*, 23(127): 29–43.
- Swane, CE and Tireli, Ü.** 2011b. Tyrkiske ældres pendling: Positioner og fællesskaber på tværs af livslobet [Circular Turkish elderly people: Positions and communities across the life span]. *Gerontologi*, 4: 4–7.
- Taylor, R.** 2013. The politics of securing borders and the identities of disease. *Sociology of Health and Illness*, 35(2): 241–54. DOI: <https://doi.org/10.1111/1467-9566.12009>
- Tireli, Ü, Mikkelsen, P, Engelbrechtsen, RW and Bram Nielsen, SM.** 2007. *Livet som ældre etnisk minoritet i Danmark* [The life as older ethnic minority in Denmark] – *Et projekt økonomisk støttet af EGV Fonden* – CVU Storkøbenhavn. København: Videncenter for Interkulturel Pædagogik, Sydhavns Plads.
- Torres, S.** 2001. *Understanding 'successful aging': Cultural and migratory perspectives*. PhD-Thesis. Sweden: Department of Sociology, Uppsala University.
- Torres, S.** 2006. Elderly immigrants in Sweden: "Otherness" under construction. *Journal of Ethnic and Migration Studies*, 32(8): 1341–58. DOI: <https://doi.org/10.1080/13691830600928730>
- Torres, S.** 2012. International migration: Patterns and implications for exclusion in old age. In: Scharff, T, et al. (eds.), *From Exclusion to Inclusion in Old Age: A Global Challenge*. Bristol: Policy Press. pp. 33–49. DOI: <https://doi.org/10.1332/policypress/9781847427731.003.0003>
- Torres, S.** 2013. Transnationalism and the study of aging and old age. In: Phellas, C (ed.), *Aging in European societies. International perspectives on aging*, vol 6. Boston: Springer. pp. 267–281. DOI: https://doi.org/10.1007/978-1-4419-8345-9_18
- Üçok, M.** 2006. Transnational consumption practices for social mobility: A study of Turkish immigrants in Denmark. *AMID Working Paper Series 58/2006*. Odense: Akademiet for Migrationsstudier, Syddansk Universitet.
- Udlændinge- og integrationsministeriet.** 2019. International Migration – Denmark. *Report to OECD*, October 2019. Available at <https://integrationsbarometer.dk/tal-og-analyser/filer-tal-og-analyser/arkiv/SOPEMI2019.pdf>.
- UNECE.** 2016. Policy Brief: Migration and older age. Older migrants and migrant care workers. *UNECE Policy Brief on Ageing No. 17*, July 2016. http://www.unece.org/fileadmin/DAM/pau/age/Policy_briefs/ECE-WG.1-24.pdf.
- United Nations.** 2013. *International Migration 2013: Age and Sex Distribution. Population Facts No. 2013/4*. Department of Economic and Social Affairs – Population Division. Available at <http://www.un.org/en/development/desa/population/theme/international-migration/>.
- Vertovec, S.** 2009. *Transnationalism*. London and New York: Routledge. DOI: <https://doi.org/10.4324/9780203927083>
- Walsh, K and Näre, L.** (eds.) 2016. *Transnational migration and home in older age*. London and New York: Routledge. DOI: <https://doi.org/10.4324/9781315713564>
- Warnes, A and Williams, A.** 2006. Older Migrants in Europe: A New Focus for Migration Studies. *Journal of Ethnic and Migration Studies*, 32(8): 1257–1281. DOI: <https://doi.org/10.1080/13691830600927617>
- WHO.** 2010. *Health of Immigrants – The Way Forward. Report of a Global Consultation, Madrid, Spain 3–5 March 2010*. Available at <http://apps.who.int/iris/handle/10665/44336>.

- WHO.** 2015. *Ageing and health. Fact sheet N°404*. September 2015. Available at <http://www.who.int/mediacentre/factsheets/fs404/en/> [Last accessed 1 January 2018].
- WHO.** 2018. *Refugee and migrant health*. Available at <http://www.who.int/migrants/en/> [Last accessed 1 January 2018].
- Wimmer, A** and **Glick Schiller, N.** 2002. Methodological nationalism and beyond: Nation-state building, migration and the social sciences. *Global Networks*, 2(4): 301–34. DOI: <https://doi.org/10.1111/1471-0374.00043>
- Wismar, M, Palm, W, Figueras, J, Ernst, K** and **Van Ginneken, E.** 2011. *Cross-border health-care in the European Union: Mapping and analysing practices and policies*. Geneva: WHO.
- Zubair, M** and **Norris, M.** 2015. Perspectives on ageing, later life and ethnicity: Ageing research in ethnic minority contexts. *Ageing & Society*, 35: 897–916. DOI: <https://doi.org/10.1017/S0144686X14001536>

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